DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DETERMINATION/PRONOUNCEMENT OF DEATH IN THE FIELD** (EMT/ PARAMEDIC/MICN) REFERENCE NO. 814

PURPOSE: This policy is intended to provide EMS personnel with parameters to determine whether or not to withhold resuscitative efforts in accordance with the patient's wishes, and to provide guidelines for base hospital physicians to discontinue resuscitative efforts and pronounce death.

AUTHORITY: California Health and Safety Code, Division 2.5
California Probate Code, Division 4.7
California Family Code, Section 297-297.5

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows patients who are unable to speak for themselves to provide health care instructions and/or appoint a Power-of-Attorney for Health Care. There is no one standard format for an AHCD. Examples of AHCDs include:

- Durable power of attorney (DPAHC)
- Healthcare proxies
- Living wills (valid in California if dated prior to 7-1-2000; advisory but not legally binding after that date)

Agent: An individual, eighteen years of age or older, designated in a power of attorney for health care to make health care decisions for the patient, also known as "attorney-in-fact".

Conservator: Court-appointed authority to make health care decisions for a patient.

Determination of Death: To conclude that a patient has died by conducting an assessment to confirm the absence of respiratory, cardiac, and neurologic function.

Immediate Family: The spouse, domestic partner, adult children or adult sibling(s) of the patient.

Organized ECG Activity: A narrow complex supraventricular rhythm.

Pronouncement of Death: A formal declaration by a base hospital physician that life has ceased.

Standardized Patient-Designated Directives: Forms or a medallion that recognize and accommodate a patient's wish to limit prehospital treatment at home, in long term care facilities or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association

APPROVED: _____ Director _____ Medical Director

(CMA) Prehospital DNR Form, (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No. 815.2)
- State EMS Authority-approved DNR Medallion

PRINCIPLES:

1. Resuscitative efforts are of no benefit to patients whose physical condition precludes any possibility of successful resuscitation.

2. EMTs and paramedics may **determine** death based on specific criteria set forth in this policy.

3. Base hospital physicians may **pronounce** death based on information provided by the paramedics in the field and guidelines set forth in this policy.

4. If there is any objection or disagreement by family members or EMS personnel regarding terminating or withholding resuscitation, basic life support (BLS) resuscitation, including defibrillation, may continue or begin immediately and paramedics should contact the base hospital for further directions.

5. Aggressive resuscitation in the field to obtain the return of spontaneous circulation (ROSC) is encouraged. Transporting patients without ROSC is discouraged.

6. EMS personnel should honor valid do-not-resuscitate (DNR) orders and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

POLICY:

I. Determination of Death, Base Hospital Contact Not Required:

A. A patient may be determined dead if, in addition to the absence of respiration, cardiac activity, and neurologic reflexes, one or more of the following physical or circumstantial conditions exist:

1. Decapitation

2. Massive crush injury

3. Penetrating or blunt injury with evisceration of the heart, lung or brain

4. Decomposition

5. Incineration

6. Pulseless, non-breathing victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.

7. Penetrating trauma patients who, based on the paramedic's thorough assessment, are found apneic, pulseless, asystolic, and without pupillary reflexes upon the arrival of EMS personnel at the scene.

8. Blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) upon the arrival of EMS personnel at the scene.

9. Pulseless, non-breathing victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.

10. Drowning victims, when it is reasonably determined that submersion has been greater than one hour.

11. Rigor mortis (requires assessment as described in Section I, B.)

12. Post-mortem lividity (requires assessment as described in Section I, B.)

B. If the initial assessment reveals rigor mortis and/or post-mortem lividity only, EMTs and/or paramedics shall perform the following assessments (may be performed concurrently) to confirm the absence of respiratory, cardiac, and neurologic function for determination of death in the field:

1. Assessment of respiratory status:

   a. Assure that the patient has an open airway.

   b. Look, listen and feel for respirations. Auscultate the lungs for a minimum of 30 seconds to confirm apnea.

2. Assessment of cardiac status:

   a. Auscultate the apical pulse for a minimum of 60 seconds to confirm the absence of heart sounds.

   b. Adults and children: Palpate the carotid pulse for a minimum of 60 seconds to confirm the absence of a pulse.

   c. Infants: Palpate the brachial pulse for a minimum of 60 seconds to confirm the absence of a pulse.

3. Assessment of neurological reflexes:

   a. Check for pupillary response with a penlight or flashlight to determine if pupils are fixed and dilated.

   b. Check and confirm unresponsive to pain stimuli.

C. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I. A. require immediate BLS measures to be initiated while

EMS personnel assess for one or more of the following:

1. A valid standardized patient-designated directive indicating DNR.

2. A valid AHCD with written DNR instructions or the agent identified in the AHCD requesting no resuscitation.

3. Immediate family member present at scene:

   a. With a patient-designated directive on scene requesting no resuscitation.

   b. Without said documents at scene with full agreement of others, if present, requesting no resuscitation.

4. Parent or legal guardian is required and must be present at scene to withhold or terminate resuscitation for patients less than 18 years of age.

5. Patient in asystole without CPR and the estimated time from collapse to bystander CPR or EMS initiating BLS measures is greater than 10 minutes. Collapse is a sudden fall or loss of function with the victim unconscious, and not breathing normally.

If one or more of the conditions in Section I. C. is met, BLS measures may be discontinued and the patient is determined to be dead.

II. Patients in Cardiopulmonary Arrest Requiring Base Hospital Contact:

A. Base contact shall be established for all patients who do not meet the conditions described in Section I of this policy.

B. The base hospital physician may pronounce death when it is determined that further resuscitative efforts are futile. Patients without ROSC after 20 minutes of resuscitative efforts by EMS personnel should be considered candidates for termination of resuscitation. Exceptions may include hypothermia or patients who remain in, or whose rhythm changes to, ventricular fibrillation or pulseless ventricular tachycardia.

III. Crime Scene Responsibility, Including Presumed Accidental Deaths and Suspected Suicides:

A. Responsibility for medical management rests with the most medically qualified person on scene.

B. Authority for crime scene management shall be vested in law enforcement. To access the patient it may be necessary to ask law enforcement officers for assistance to create a “safe path” that minimizes scene contamination.

C. If law enforcement is not on scene, EMS personnel should attempt to create a "safe path" and secure the scene until law enforcement arrives.

IV. Procedures Following Pronouncement of Death:

A. The deceased should not be moved without the coroner's authorization. Any invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient should be left in place.

NOTE: If it is necessary to move the deceased because the scene is unsafe or the body is creating a hazard, EMS personnel may relocate the deceased to a safer location or transport to the most accessible receiving facility.

B. If law enforcement or the coroner confirms that the deceased will not be a coroner's case and the personal physician is going to sign the death certificate, any invasive equipment used during the resuscitation may be removed.

C. EMS personnel should remain on scene until law enforcement arrives. During this time, when appropriate, the provider should provide grief support to family members.

V. Required Documentation for Patients Determined Dead/Pronounced in the Field:

A. The time and criteria utilized to determine death; the condition, location and position of the body, and any care provided.

B. The location and the rationale if the deceased was moved. If the coroner authorized movement of the deceased, document the coroner's case number (if available) and the coroner's representative who authorized the movement.

C. Time of pronouncement and name of the pronouncing physician if base hospital contact was initiated

D. The name of the agent identified in the AHCD or patient-designated directive or the name of the immediate family member who made the decision to withhold or withdraw resuscitative measures. Obtain their signature on the EMS Report Form.

E. If the deceased is **not** a coroner's case and their personal physician is going to sign the death certificate:

a. Document the name of the coroner's representative who authorized release of the patient, and
b. The name of the patient's personal physician signing the death certificate, and
c. Any invasive equipment removed.

CROSS REFERENCE:

Prehospital Care Manual:

Reference No. 518, **Decompression Emergencies/Patient Destination**
Reference No. 519, **Management of Multiple Casualty Incidents**
Reference No. 606, **Documentation of Prehospital Care**
Reference No. 806, **Procedures Prior to Base Contact**
Reference No. 808, **Base Hospital Contact and Transport Criteria**
Reference No. 815, **Honoring Prehospital Do Not Resuscitate Orders**
Reference No. 815.1 **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
Reference No. 819, **Organ Donor Identification**
Reference No. 815.2 **Physician Orders for Life-Sustaining Treatment (POLST) Form**